

KANSAS MENTAL HEALTH COALITION

.....Speaking with one voice to meet the critical needs of people with mental illness

Adult Psychiatric Inpatient Services: The State Hospitals Crisis

Position: The Kansas Legislature should support and fully fund high-quality psychiatric inpatient services to meet the needs of all Kansans who require this care. Specifically, the Legislature should: 1) Restore the 206 beds at Osawatomie State Hospital and end the moratorium on admissions, 2) Fund Regional Crisis Locations including co-located substance use disorder (SUD) services. 3) Submit Federal Waiver Application for the IMD Exclusion rule to maximize federal funds. 4) Provide for continued public/private partnerships for regional psychiatric inpatient beds. 5) Implement the Crisis Intervention Act. Opening facilities that can be certified for short term commitment and stabilization will require new rules and regulations and funding. 6) Develop a long-term plan to implement the recommendations of the 2018 Mental Health Task Force Report and the Adult Continuum of Care Committee.

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The problem: The state's psychiatric inpatient system is broken. Simply put, it does not have the capacity to meet the current demand to serve Kansans who need inpatient treatment. Osawatomie State Hospital has lost its CMS certification for the majority of the hospital. Adair Acute Care at Osawatomie is the acute care 60 bed unit that has recently been recertified and must operate as an independent hospital. The fact is, mental health advocates have been warning of the potential crisis for more than ten years, and needed investments in facilities, technology, training and salaries have been repeatedly delayed. The recent negative surveys at Larned State Hospital confirm that our hospitals need ongoing attention.

Why this matters: Of those who use our state hospitals, more than 70 percent do not have Medicaid or other forms of reimbursement, limiting their access to private hospital beds. All this underscores the need to support a state mental health hospital system as a safety net for those who experience a mental health crisis. Without that safety net, many of these individuals regularly interact with law enforcement or are seen in emergency rooms, shifting the cost to other systems. Whether public or private, underfunded inpatient facilities are not safe for patients or staff and they do not produce lasting recovery for patients, so we cannot reallocate hospital funding without jeopardizing lives. The moratorium on admissions means that people who are in crisis and at risk of harming themselves or others must wait for needed treatment. There are no voluntary admissions under the moratorium, so every case must go through the legal process for involuntary commitment. Kansas law enforcement organizations and community hospitals identify the moratorium at Osawatomie State Hospital as a crisis that must be resolved as soon as possible. And now, they report that dozens of individuals who have been involuntarily committed are being rejected by the state hospital due to their diagnosis or unrelated medical conditions. If indeed our state hospitals cannot serve these individuals, we must provide a resource that can. This system is far from providing the right care, at the right time, in the right place.

The bottom line: The 2018 Mental Health Task Force Report asserts that inpatient capacity must expand and community based programs, including crisis stabilization services, substance use disorder treatment and detox services (inpatient and outpatient), and housing resources must be a part of the solution. The hospitals need investments in staff, training, and new facilities, paired with community strategies that provide for recovery.

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The rest of the story, from the 2018 Mental Health Task Force Report

Recommendations regarding Privatization: (KDADS is pursuing a privatization contract for Osawatomie, but it has not yet negotiated a contract to be brought before the Legislature for approval.)

- *Recommendation 4.1: Comprehensive Approach.* While the Task Force appreciates the intention of the current request for proposal (RFP) to create better and safer treatment and work environments for patients and staff at Osawatomie State Hospital, any proposal involving new construction should only be executed as part of a comprehensive financing package addressing a full range of needs in the behavioral health system for mental health and substance abuse disorder treatment, including inpatient and outpatient community-based services, crisis stabilization, housing, and peer programs.
- *Recommendation 4.2: Regional Model.* In lieu of a single RFP, the Task Force recommends a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute psychiatric crisis. The state hospital setting must continue to provide both acute services as well as longer-term/tertiary specialized care.
- *Recommendation 4.3: Vigorous Oversight.* Any process that could result in privatized services – including requests for proposals as well as oversight of any resulting privatized facility – should include thorough and ongoing oversight, including an advisory board to include clinicians, accountants, legal counsel, persons with lived experience who are in recovery, persons with lived experience who have been voluntarily and involuntarily hospitalized, family members and guardians of persons with mental illness, Community Mental Health Center staff, law enforcement and community corrections, and advocacy organizations. If a single bidder responds to any RFP, additional oversight may be required.

Number of Beds

The Task Force did recommend adding up to 300 additional inpatient behavioral health beds – a number that was derived from two research documents. A report from the Treatment Advocacy Center in 2016 solicited the input of experts in the field of mental health to establish an appropriate number of beds for inpatient mental health at 40 to 60 beds per 100,000. Research from North Carolina found that, without expansion of community-based psychiatric resources or other treatment options, the number of beds needed there to reach appropriate capacity for same-day admissions to inpatient psychiatric beds was 39 beds per 100,000 excluding forensic beds. The Task Force recommends that there be a study similar to the analysis for North Carolina to determine exact bed needs in Kansas. In the meantime, the state should work toward a goal of 39 beds per 100,000 adults (18 and older) until such time that a larger analysis is completed. The Task Force further recommends that the beds be geographically dispersed based on population density to best provide services to those in need. However, the Task Force noted that the need for additional beds could be reduced if the state were to invest in the creation or expansion of alternatives, including many of the priority recommendations in this and prior reports.

Note: Currently, Osawatomie State Hospital has the staffing capacity to treat 158 patients and promises to expand to 170 soon, but only the Adair Acute Care beds (60) can receive federal funds.

Regionalization

The Task Force believes that Kansas must develop a more balanced system to address behavioral health needs in Kansas. To address the needs of the Kansas population statewide, a regional model should be developed to provide access closer to home for more patients. Regional short-term, acute-care facilities that accept both voluntary and involuntary admissions would allow the two state hospitals to dedicate more beds to longer-term inpatients.

To have a balanced system of care that provides appropriate access to treatment, the model developed must assure more services are available locally, including access to acute care. Both community and hospital services are needed, though different models may be used to provide the services. Further, evidence suggests that rural psychiatric inpatient units improve access to community-based mental health services.